

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09476

9482

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deal Island	c. LENGTH OF STAY IN 1b all life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Deal Island	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Terria Middle Gayvonne Last Bivens		4. DATE OF DEATH Month August 4, Day 19 Year 58	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1958
9. AGE (In years last birthday) 6 month		IF UNDER 1 YEAR Months 4 Days 4 Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland (hosp.)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Bivens		14. MOTHER'S MAIDEN NAME Henrietta Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Clarence Bivens - Deal Island, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 921.0 Found dead in crib DUE TO (b) Suffocation from milk DUE TO (c) and bed covers - CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			INTERVAL BETWEEN ONSET AND DEATH 7
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Milk from bottle + bed covers -	
20c. TIME OF INJURY Month, Day, Year 5-3 - 8-4 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Deal Island Somerset Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. H. Johnson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. H. Johnson		DATE SIGNED Aug 8 - 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/5/58	22c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY	22d. LOCATION (City, town, or county) (State) Deal Island MD
23. FUNERAL DIRECTOR'S SIGNATURE L. B. Webster		24a. REC'D BY REGISTRAR AUG 7 '58	24b. REGISTRAR'S SIGNATURE R. H. Johnson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Found dead in ditch
No apparent cause of death
No other remarks

Age 45 years
Sex Male
Race White
Occupation Farmer

Signature of Physician
J. H. Johnson
Date 1-2-1928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the registrars, the registrars' page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9483

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 233 9-2-58 et

CERTIFICATE OF DEATH

09477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	
c. LENGTH OF STAY IN 1b 51 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL		d. STREET ADDRESS NINTH & BROAD STREET	
3. NAME OF DECEASED (Type or print) First Middle Last EDDIE VERNON COLLINS		4. DATE OF DEATH Month Day Year AUGUST 24 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/18/1907
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM COLLINS		14. MOTHER'S MAIDEN NAME MISSOURI BROADWATER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MARY TAYLOR		Address MARDON, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Myocarditis 322.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Enteritis & Diarrhea DUE TO (c) Chronic Alcoholism INTERVAL BETWEEN ONSET AND DEATH 1 day 3 weeks Several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonism Epilepsy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1955 to Aug. 24, 1958 , that I last saw the deceased alive on Aug. 24, 1958 , and that death occurred at 7:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND DATE SIGNED 8/25/58			
ACTUAL SIGNATURE A. N. BARR, M.D.		M.D. CRISFIELD, MARYLAND	
PHYSICIAN'S NAME (Type) A. N. BARR, M.D.		CRISFIELD, MARYLAND	
22a. BURIAL, CREMATION, REMAINS (Specify) Burial	22b. DATE THEREOF Aug. 26, 1958	22c. NAME OF CEMETERY OR CREMATORY Mariners Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

CERTIFICATE OF DEATH

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of attending physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09478

Reg. Dist. No.

9484

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage Grove</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover R.F.D.</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucinda</u> First <u>Pauline</u> Middle <u>Cattman</u> Last		4. DATE OF DEATH <u>Aug</u> 13 1958	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 13 58</u>
9. AGE (In years last birthday) <u>13</u> yrs.		10. IF UNDER 1 YEAR <u>13</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christopher Cattman</u>		14. MOTHER'S MAIDEN NAME <u>Corine Viola Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Maggie Smith Westover R.F.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Prenatally - 7 months -</u> Conditions, if any, which gave rise to immediate cause (b) <u>13 hrs.</u> (c) <u>13 hrs.</u> DUE TO <u>13 hrs.</u> DUE TO <u>13 hrs.</u> DUE TO <u>13 hrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R.H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.H. Johnson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>August 14 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town or county) (State) <u>Cottage Grove</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Father - Christopher Cattman</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>AUG 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

4000202XV3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. The file pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Decedent
Elliott, John W.
Married

Age 38
Date of Death 12-14-28
Place of Death St. Louis, Mo.

Cause of Death
Chronic Bronchitis
Pneumonia

Signature of Physician
R. H. Johnson
Date 12-14-28
Place of Death St. Louis, Mo.

CERTIFICATE OF DEATH

Reg. Dist. No.

09479

1. PLACE OF DEATH o. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WENONA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WENONA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HOME		d. STREET ADDRESS 1 MAIN ROAD	
3. NAME OF DECEASED (Type or print) WILLIAM C. DASHIELL		4. DATE OF DEATH August 12 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 11-1876
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL DASHIELL		14. MOTHER'S MAIDEN NAME MELISSA TYLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-01-5586	
17. INFORMANT Mrs Della DASHIELL - WENONA		Address Wife MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) years			INTERVAL BETWEEN ONSET AND DEATH 3 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) congestive failure			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-10-58 , 19____, to 8-12-58 , 19____, that I last saw the deceased alive on 8-12-58 , 19____, and that death occurred at 10am M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Everett C. Sutter MD		ADDRESS (Street, city or town, state) Danes Quarter, Maryland DATE SIGNED 8-12-58	
PHYSICIAN'S NAME (Type) Everett C. Sutter MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Aug-14-58	22c. NAME OF CEMETERY St. Ann's M.E.	22d. LOCATION (City, town, or county) (State) Deal Island MD
23. FUNERAL DIRECTOR'S SIGNATURE L. S. Webster		24a. REC'D BY REGISTRAR AUG 19 58	24b. REGISTRAR'S SIGNATURE

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

522-10-110

doi:10.1017/S0022292410000501

Journal of Interpersonal Violence 26(12)

also on the left side of the head.

2004

— I — I —

1-1

[illegible]

DOI: 10.1002/for

CERTIFICATE OF DEATH

Reg. Dist. No.

09480

9486

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomack			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edw. W. McCready Memorial Hosp.				d. STREET ADDRESS RFD			
3. NAME OF DECEASED (Type or print) First Pamela Middle Ann Last Fletcher				4. DATE OF DEATH Month 8 Day 8 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-58		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	IF UNDER 24 HRS.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland	
13. FATHER'S NAME Leroy Fletcher				14. MOTHER'S MAIDEN NAME Patsy Ann Ross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -----		17. INFORMANT Patsy Fletcher, New Church, Virginia Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature Congenital defect 756.2 DUE TO Cherry abdominal wall C. Complex Encephalocele of Back Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Congenital defect in Cherry of abdominal wall (c) Congenital defect in Cherry of abdominal wall				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature, Born normal with complex Encephalocele				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Congenital defect of Abdominal Wall			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 8-7 , 19 58 , to 8-8 , 19 58 , that I last saw the deceased alive on 8-8 , 19 58 , and that death occurred at 10:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE George C. Boulbroun M.D.							
PHYSICIAN'S NAME (Type) George C. Boulbroun M.D. Jrcs							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Holly		22d. LOCATION (City, town, or county) (State) Accomack, VA	
23. FUNERAL DIRECTOR'S SIGNATURE Whitely Williams ADDRESS				24a. REC'D BY REGISTRAR AUG 11 '58		24b. REGISTRAR'S SIGNATURE Quinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon (if any). Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECLARATION OF DEATH

MANITOWOC STATE DEPT OF HEALTH - BALTIMORE 10

Form with multiple lines for text entry, including fields for name, address, date, and signature.

Vertical text on the right margin, possibly a date or reference number.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9487

09481

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Kingstowna</u>		c. LENGTH OF STAY IN TB hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		d. STREET ADDRESS <u>7 Delaware Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Floyd Johnson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1919</u>		9. AGE (in years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>213-14-6244</u>		17. INFORMANT <u>Nettie Johnson - Parsonsburg, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation in Water</u> DUE TO <u>Drown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Swimming - Went Down Did not come UP</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>1:00</u> p.m. <u>8-3</u> <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, street, office bldg., etc.) <u>River</u>		20f. (City or town) (County) (State) <u>Kingston Somerset Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R.H. Johnson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.H. Johnson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 8 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Oak Bur</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. ...</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

• 本日の午後、午後一時から二時までは、
午前九時から午後五時まで

1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right. The names are: "John A. Smith", "John B. Smith", "John C. Smith", "John D. Smith", "John E. Smith", "John F. Smith", "John G. Smith", "John H. Smith", "John I. Smith", "John J. Smith", "John K. Smith", "John L. Smith", "John M. Smith", "John N. Smith", "John O. Smith", "John P. Smith", "John Q. Smith", "John R. Smith", "John S. Smith", "John T. Smith", "John U. Smith", "John V. Smith", "John W. Smith", "John X. Smith", "John Y. Smith", "John Z. Smith". The dates are: "1840", "1841", "1842", "1843", "1844", "1845", "1846", "1847", "1848", "1849", "1850", "1851", "1852", "1853", "1854", "1855", "1856", "1857", "1858", "1859", "1860", "1861", "1862", "1863", "1864", "1865", "1866", "1867", "1868", "1869", "1870", "1871", "1872", "1873", "1874", "1875", "1876", "1877", "1878", "1879", "1880", "1881", "1882", "1883", "1884", "1885", "1886", "1887", "1888", "1889", "1890", "1891", "1892", "1893", "1894", "1895", "1896", "1897", "1898", "1899", "1900".

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

CERTIFICATE OF DEATH

09482

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHANCE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHANCE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EARNIE JONES		4. DATE OF DEATH AUGUST 28 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 22-1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM KELLY	
14. MOTHER'S MAIDEN NAME CATHERINE SHORES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT DANIEL JONES - HUSBAND - CHANCE MD Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic heart disease DUE TO and Hypertensive cardiovascular disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetic mellitus			INTERVAL BETWEEN ONSET AND DEATH 16 hours years years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-20-56 , 19____, to 8-28-58 , 19____, that I last saw the deceased alive on 8-28-58 , 19____, and that death occurred at 5:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damos Quarter, Maryland DATE SIGNED 8-30-58			
ACTUAL SIGNATURE Everett C. Sutter M.D.		PHYSICIAN'S NAME (Type) Everett C. Sutter	
22a. BURIAL, CREMATION, EMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATOR	22d. LOCATION (City, town, or county) (State)
Burial	8/31/58	CHANCE METHODIST	CHANCE MD.
23. FUNERAL DIRECTOR'S SIGNATURE L. G. Webster ADDRESS Seal Deland Md		24a. REC'D BY REGISTRAR DATE SEP 8 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kious

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9489

CERTIFICATE OF DEATH

Reg. Dist. No. 09483

1. PLACE OF DEATH, a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>		d. STREET ADDRESS <u>MAIN ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First Middle Last <u>KELLY</u>		4. DATE OF DEATH <u>AUGUST 18</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25-1879</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>DEAL ISLAND MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILBUR KELLY</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE WEBSTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS ELLA KELLY - WIFE</u> Address <u>MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Congestive failure</u> DUE TO (c) <u>Arteriosclerotic heart failure</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>severe arthritis, cerebral vascular accident 3 yr ago, uremia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. <u>bed sores-3 yr duration, malnutrition severe</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-15-58</u> , 19 <u>58</u> , to <u>8-18-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-18-58</u> , 19 <u>58</u> , and that death occurred at <u>7p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Dames Quarter, Maryland</u> DATE SIGNED <u>8-18-58</u>			
ACTUAL SIGNATURE <u>Everett C. Sutter</u>		PHYSICIAN'S NAME (Type) <u>Everett C. Sutter</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 20 1958</u>	
22c. NAME OF CEMETERY <u>ST. JOHNS M.E.</u>		22d. LOCATION (City, town or county) (State) <u>Deal Island Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster - Deal Island</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>AUG 22 '58</u>	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09484

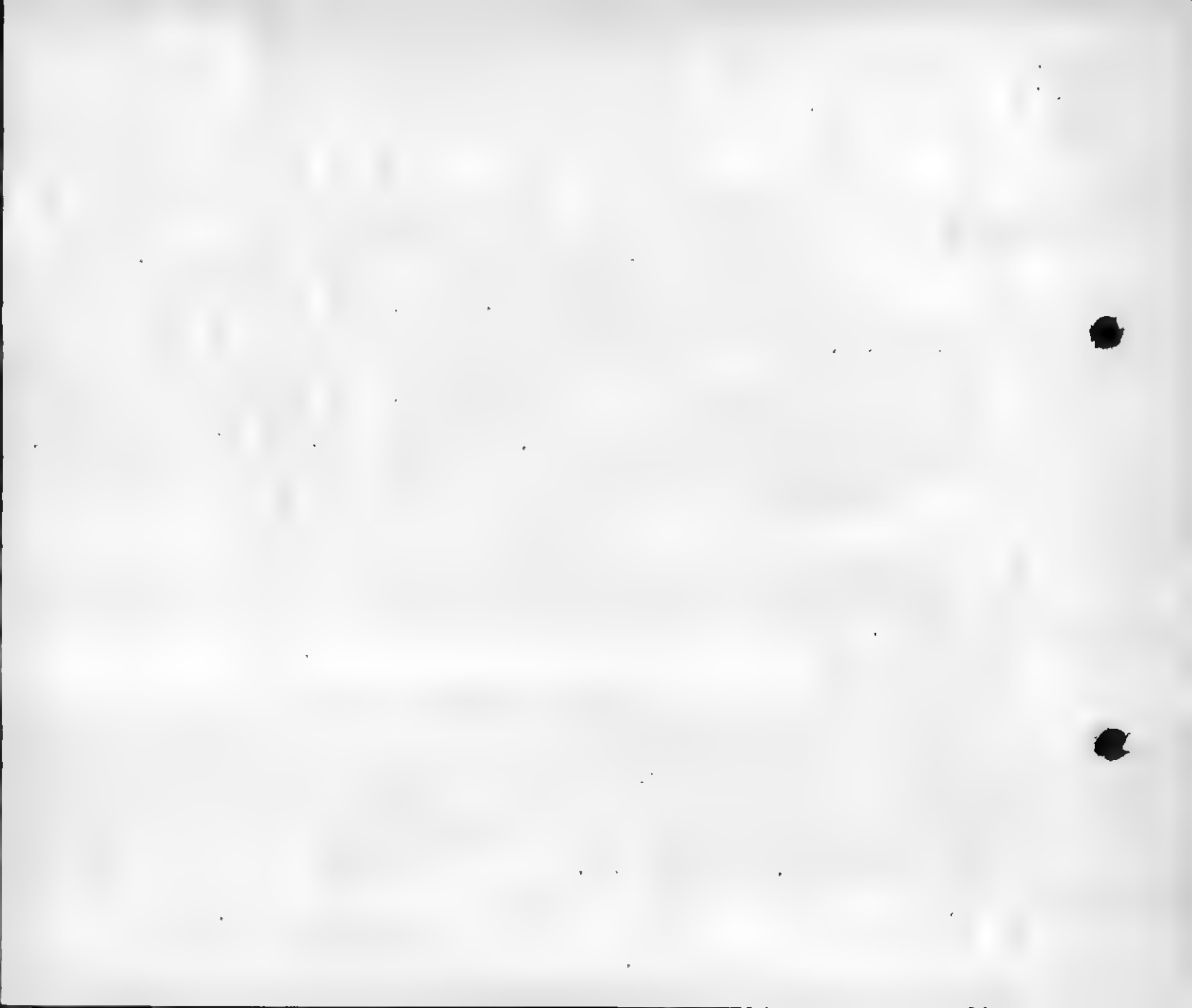
9490

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1
 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Enroute to McGready Hospital				d. STREET ADDRESS Box 654, Freemantown, Crisfield		e. IS RE INTERMENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RAPHAEL LEMCKINS				4. DATE OF DEATH August 11, 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1913		9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crab Picker		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harrison Lemckins				14. MOTHER'S MAIDEN NAME Odelia ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Mrs. Mildred Lemckins, Box 654, Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion + D.O.I. DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had coronary attack on Street and died enroute to hospital by car							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Wm H Coulbourn</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William H. Coulbourn, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/58		22c. NAME OF CEMETERY OR CREMATORY Lawsonia Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.				24a. REC'D BY REGISTRAR DATE AUG 18 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	



CERTIFICATE OF DEATH

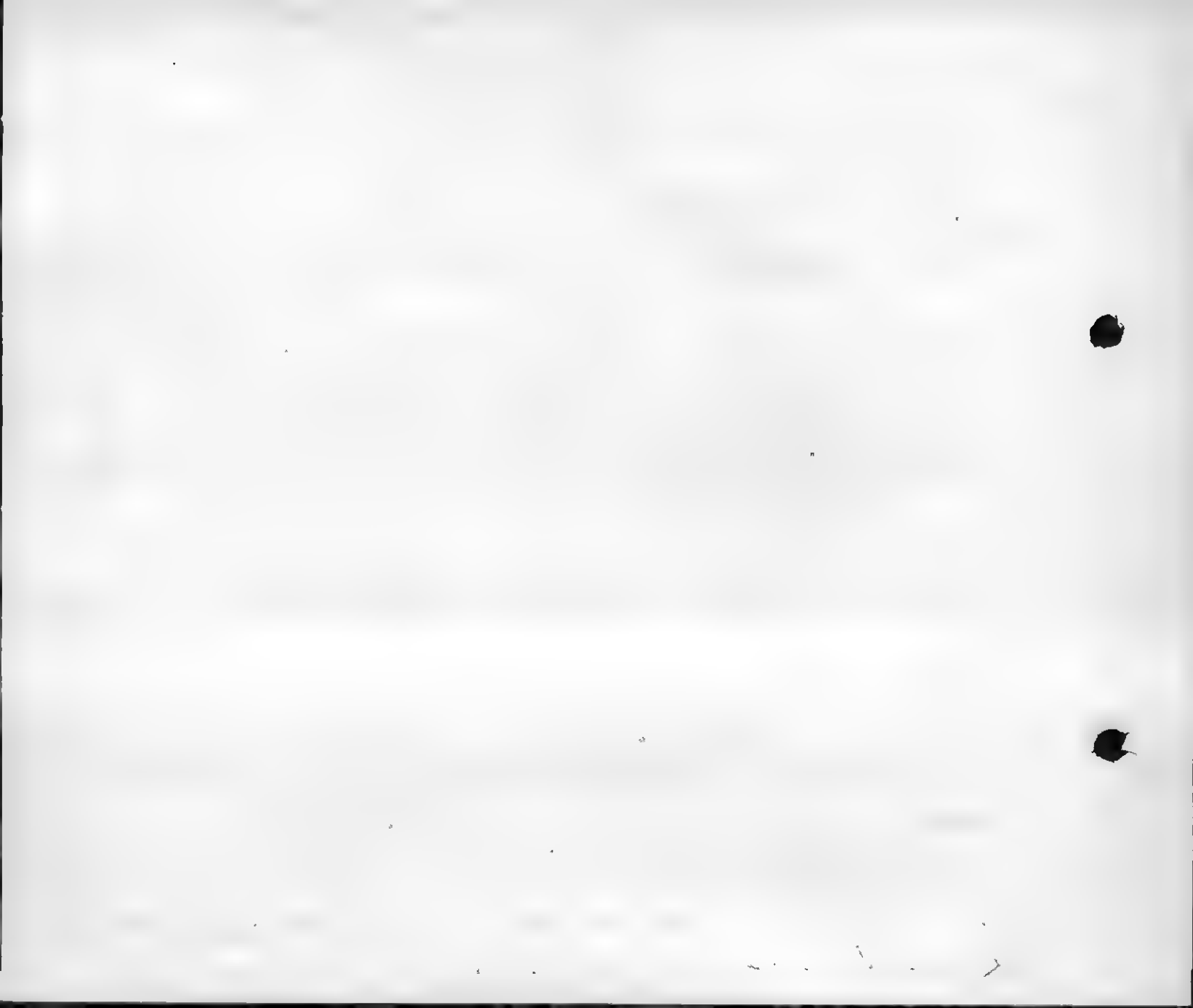
Reg. Dist. No.

9491

1. PLACE OF DEATH a. COUNTY SOMERSET b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. MCCREADY MEMORIAL HOSP.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD d. STREET ADDRESS RFD #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERMAN Middle F Last NELSON		4. DATE OF DEATH Month 8 Day 12 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 1887 9. AGE (In years last birthday) yrs. 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CRISFIELD Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN H. NELSON	
14. MOTHER'S MAIDEN NAME Betty Lawson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) XX Yes War 5.1	
16. SOCIAL SECURITY NO		17. INFORMANT CLARENCE NELSON, CRISFIELD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 153.3 Acute intestinal obstruction DUE TO (b) Carcinoma sigmoid DUE TO (c) months? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1958 to Aug 1958 , that I last saw the deceased alive on 8-12-1958 , and that death occurred at 11:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND DATE SIGNED Aug 1 1958			
ACTUAL SIGNATURE C. G. Rawley		M.D. CRISFIELD, MARYLAND	
PHYSICIAN'S NAME (Type) C. G. RAWLEY, M.D.		CRISFIELD, MARYLAND	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
burial	8/15/58	American Legion	Crisfield, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James Harmon		ADDRESS Crisfield, Md.	24a. REC'D BY REGISTRAR DATE AUG 1 1958
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy of page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9492

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09486

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chance			c. LENGTH OF STAY IN 1b 76			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chance	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Bernice Last Parks				4. DATE OF DEATH Month Aug. Day 12 Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Setp. 24n1881		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired waterman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Parks				14. MOTHER'S MAIDEN NAME Jeanette Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Ella J. Parks Chance, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 weeks years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetis, Supra Pubic Prostectomy (Prostatectomy)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-10-55 , 19____, to 8-12-58 , 19____, that I last saw the deceased alive on 8-12-58 , 19____, and that death occurred at 3A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Danns Quarter, Maryland DATE SIGNED 8-14-58							
ACTUAL SIGNATURE Everett C. Sutter		M.D. Danns Quarter, Maryland					
PHYSICIAN'S NAME (Type) Everett C. Sutter MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-14-1958		22c. NAME OF CEMETERY OR CREMATORY Chance Cemetery		22d. LOCATION (City, town, or county) (State) Chance, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Heim R. Wilson				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE AUG 25 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			



FOR STATE
HEALTH DEPT.

9494

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09487

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne c. LENGTH OF STAY IN 1b Princess Anne d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Fla. b. COUNTY Okeechobee c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Okeechobee d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Julio Perez First Middle Last		4. DATE OF DEATH Month August Day 16 Year 1958			
5. SEX Male	6. COLOR OR RACE Spanish	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4 1937		9. AGE (in years last birthday) 21 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm Work		11. BIRTHPLACE (State or foreign country) Texas	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Natibidad Perez			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address Spanish Labor Camp, New Church, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull, Internal Injuries DUE TO (b) Compound Fracture left forearm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Multiple Lacerations, Internal Injuries					INTERVAL BETWEEN ONSET AND DEATH 0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Automobile accident Princess Anne Somerset Md.			
20c. TIME OF INJURY Month, Day, Year 5:15 A.M. 8, 11 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 13 Princess Anne Somerset Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R. H. Johnson		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 11, 1958	
EXAMINER'S NAME (Type) R. H. Johnson M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Aug. 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Corpus Christim Texas	
23. FUNERAL DIRECTOR'S SIGNATURE Leim Wilson		ADDRESS Princess Anne, MD.		24a. REC'D BY REGISTRAR AUG 15 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.



... 11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09488

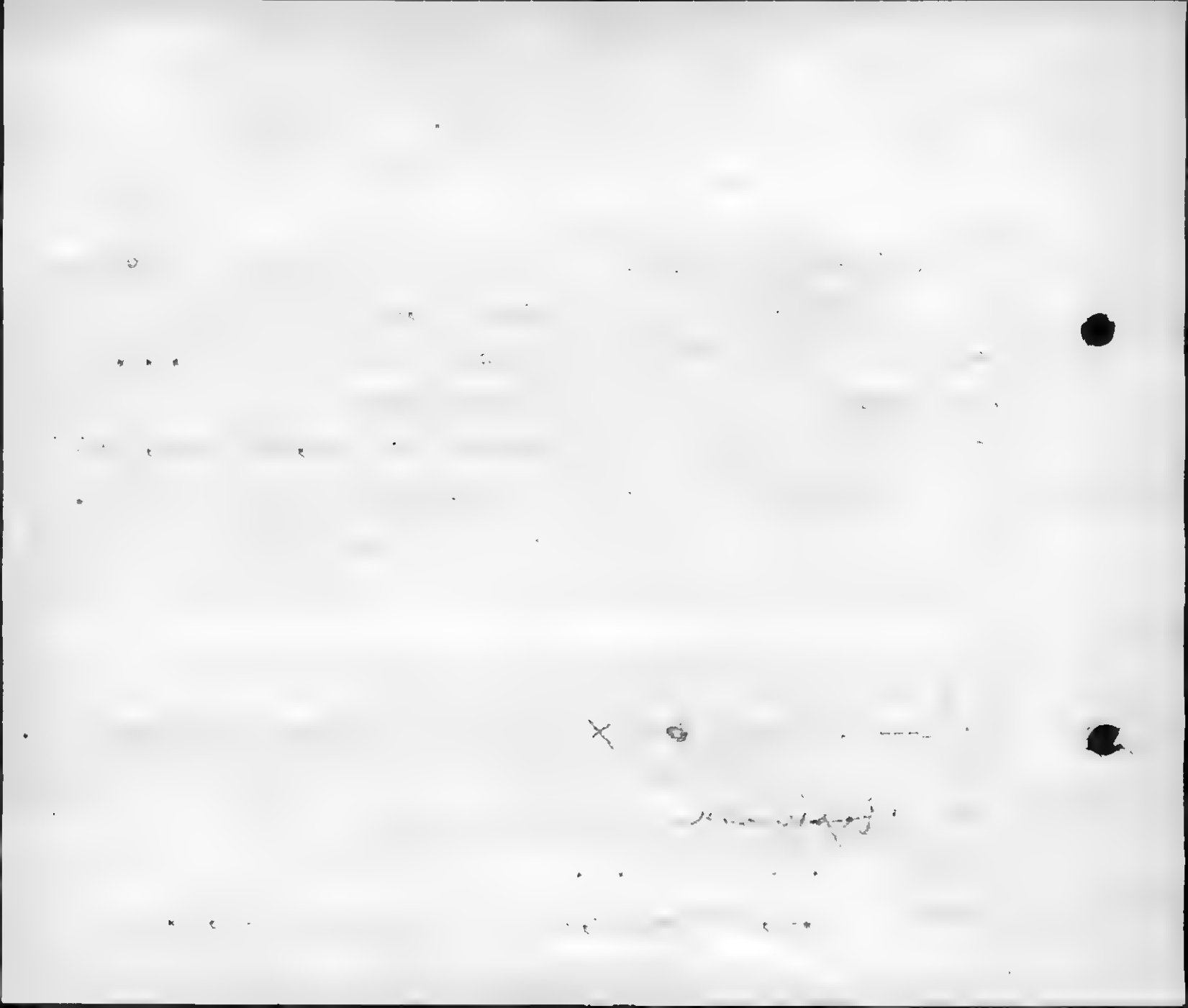
FOR STATE
HEALTH DEPT.

Reg. Dist. No.

9493

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Fla.</u> b. COUNTY <u>Okeechobee</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Okeechobee</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Otiloa Otiloa Perez</u> First Middle Last				4. DATE OF DEATH <u>August 10 1958</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Spanish</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 30, 1937</u>		9. AGE (In years last birthday) <u>20</u> yrs. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesus Gonzalez</u>				14. MOTHER'S MAIDEN NAME <u>Agoda Baskues</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Spanish Labor Camp, New Church, Virginia</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basal fracture Skull, Fracture left</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Orbital Region; Multiple lacerations</u> (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>5 Min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Automobile accident Highway 13</u>					
20c. TIME OF INJURY Month, Day, Year <u>3:15 p.m. 8, 11 1958</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 13</u>		20f. (City or town) (County) (State) <u>Princess Anne Somerset md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>R. H. Johnson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>August 11, 1958</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson M. D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Aug. 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baptist, Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Kulas</u>									
24a. REC'D BY REGISTRAR <u>AUG 11 1958</u>				24b. REGISTRAR'S SIGNATURE <u>John S. Kulas</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: A funeral certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and use as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09489

Reg. Dist. No.

9495

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE MARYLAND b. COUNTY PRINCESS ANNE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Antioch Ave.				e. STREET ADDRESS Antioch Ave.			
3. NAME OF DECEASED (Type or print) First John S. Middle Larkford Last Porter				4. DATE OF DEATH Month Aug Day 6 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 13, 1976	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 6 Days 19 Hours 50 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John S. Larkford			
14. MOTHER'S MAIDEN NAME Julia W. Corbin				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Name Mrs Iana I. Porter Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hypertensive Cardio-Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 15 min. 8 yrs. 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Feb , 1958, to Aug 6 , 1958, that I last saw the deceased alive on Aug 6 , 1958, and that death occurred at 7:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. Frank Giganti M.D.				ADDRESS (Street, city or town, state) 20 Prince William St. DATE SIGNED 8/7/58			
PHYSICIAN'S NAME (Type) B. FRANK GIGANTI				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 8-8-58				22c. NAME OF CEMETERY OR CREMATORY Antioch Methodist			
22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland				23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson ADDRESS Princess Anne, Md.			
24a. REC'D BY REGISTRAR DATE AUG 11 '58				24b. REGISTRAR'S SIGNATURE W. H. Beach			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09490

9496

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY ESSEX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. LENGTH OF STAY IN 1b 4 weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Caldwell			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 30 Overlook Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martha Middle V. Last Pusey		4. DATE OF DEATH Month August Day 7 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1867
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 90 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elias Taylor		14. MOTHER'S MAIDEN NAME Martha J. Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Dr. Everett Sutter, Dames Quarter, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis, arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 18-7-58	
21. I certify that I attended the deceased from 8-4-58 , 19____, to 8-7-58 , 19____, that I last saw the deceased alive on 8-7-58 , 19____, and that death occurred at 5:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Everett C. Sutter M.D.		ADDRESS (Street, city or town, state) Dames Quarter, Maryland DATE SIGNED 8-8-58	
PHYSICIAN'S NAME (Type) Everett C. Sutter M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 8/10/58	22c. NAME OF CEMETERY OR CREMATORY Antioch Cemetery	22d. LOCATION (City, town, or county) (State) Princess Anne, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James H. Hannon		24a. REC'D BY REGISTRAR AUG 11 '58	
ADDRESS Princess Anne, Md.		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9497

CERTIFICATE OF DEATH

09491

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne			
d. NAME OF HOSPITAL (If not in hospital, give street address) 26 Washington Ave.				d. STREET ADDRESS 26 Washington Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John First Baker Middle Roberts Last				4. DATE August 6 19 58 DEATH Month Day Year			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 11, 1879		9. AGE (In years last birthday) 79 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Freight owner of Southern Material Co.		11. BIRTHPLACE (State or foreign country) Clara, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Massey Roberts				14. MOTHER'S MAIDEN NAME Olivia White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Helen Roberts, Princess Anne, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Hypertension				INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 1956, to Aug 6 1958, that I last saw the deceased alive on Aug 6 1958, and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B. Frank Giganti M.D.				ADDRESS (Street, city or town, state) 20 Prince William St			
PHYSICIAN'S NAME (Type) B. FRANK GIGANTI				DATE SIGNED 8/7/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian	
22d. LOCATION (City, town, or county) Princess Anne				(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Levin Wilson				ADDRESS Princess Anne, Md.			
24a. REC'D BY REGISTRAR 12 1958				24b. REGISTRAR'S SIGNATURE Arthur L. Krausz			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3 and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9498

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09492

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>	c. LENGTH OF STAY IN life time	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>Main Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Shores</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 26, 1913</u>
9. AGE (in years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Inspection Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tidewater Fisheries</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Shores</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-16-9142</u>	
17. INFORMANT <u>Lottie Shores - wife - Deal Island, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		DATE SIGNED <u>Sept 2 - 1958</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Deal Island, Maryland (Som. Co.)</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster</u>		24a. REC'D BY REGISTRAR <u>SEP 4 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

...

... ..

... ..

... ..

9499

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EDW. W. MCCREADY MEMORIAL HOSP.</u>		e. STREET ADDRESS <u>RFD LAWSONIA</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EVY FRANCES STERLING</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 26 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/4/1889</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HORATIO STERLING</u>		14. MOTHER'S MAIDEN NAME <u>MARY ALLEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>LOIS S. NOONAN,</u> Address <u>CRISFIELD, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, hemiplegia, rt.</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen'l arteriosclerosis -</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 days - years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>Aug</u> , 1958, that I last saw the deceased alive on <u>Aug. 26</u> , 1958, and that death occurred at <u>10:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>C. G. Rawley</u> M.D.		<u>CRISFIELD, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>C. G. RAWLEY, M.D.</u>		<u>CRISFIELD, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 29, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunnyridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Crisfield, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw & Sons—Crisfield, Md.</u> ADDRESS		24a. REG'D BY REGISTRAR <u>AUG 28 58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Edna S. Travis</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and taken to the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

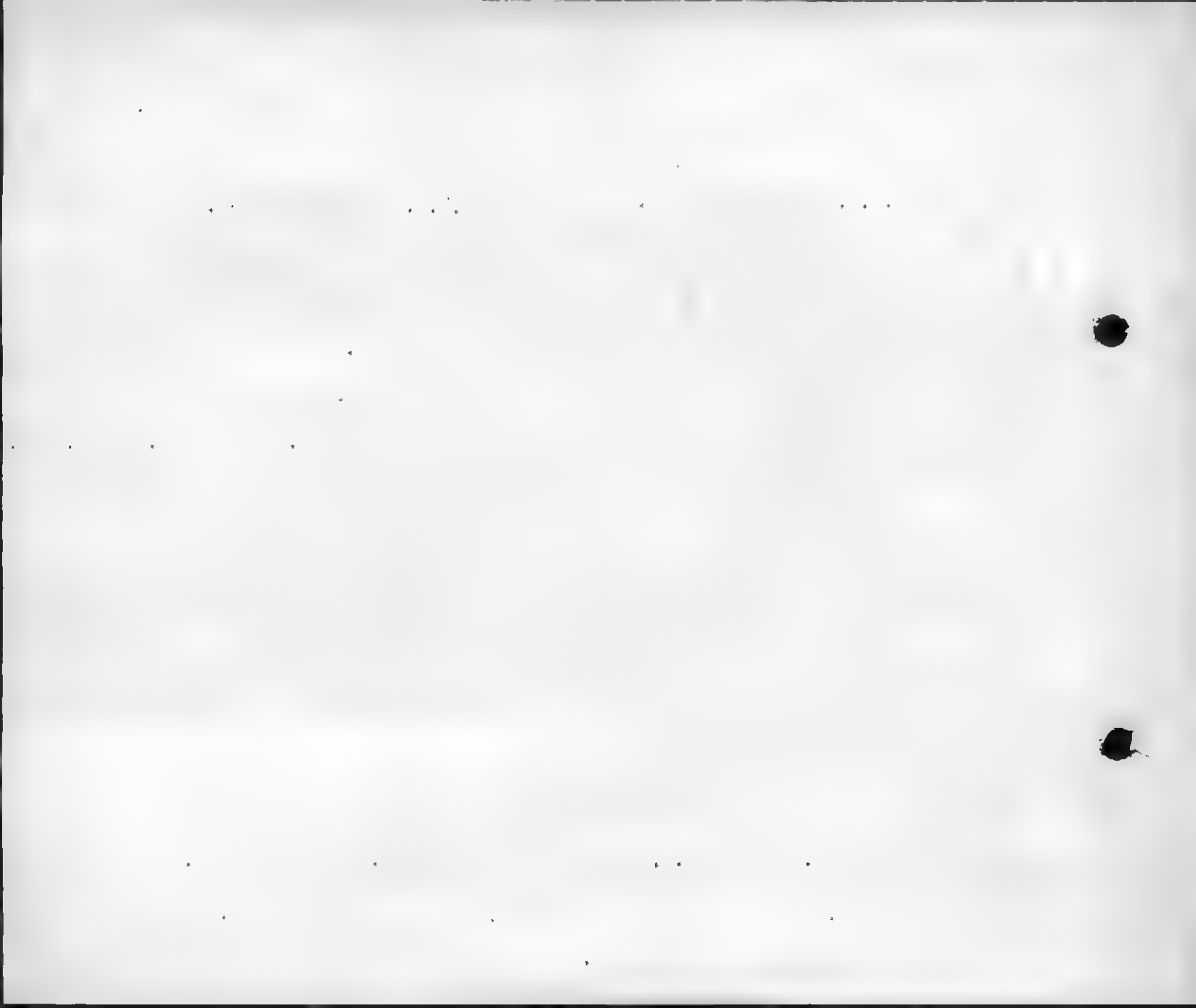
09494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Jacksonville Rd.		e. STREET ADDRESS R.F.D. Jacksonville Rd.	
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle FRANK Last WARD		4. DATE OF DEATH Month August Day 3 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1866
9. AGE (In years lost birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer and Waterman		10b. KIND OF BUSINESS OR INDUSTRY Farming & Seafood	
11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME John Ward		14. MOTHER'S MAIDEN NAME Irene Daugherty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Nellie Ward--2129 N. Calvert St.--Balto., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO SSDX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) 3 days INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Artery Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 31, 1958 to Aug 3, 1958 , that I last saw the deceased alive on Aug 2, 1958 , and that death occurred at 3:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Sarah M. Peyton M.D.			
PHYSICIAN'S NAME (Type) Sarah M. Peyton, M.D.		Main St.--Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1958	
22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		ADDRESS	
24a. REC'D BY REGISTRAR AUG 8 '58		24b. REGISTRAR'S SIGNATURE W. H. Keach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9501

CERTIFICATE OF DEATH

09495

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Somerset</u> MARYLAND CITY OR TOWN <u>Marion Station</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Somerset</u> CITY OR TOWN <u>Marion Station</u> STREET ADDRESS _____ (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Lewis</u> (First) <u>Whittington</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>Aug 8</u> 19 <u>58</u> (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 30 1888</u> 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafarer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Marion Station</u>
13. FATHER'S NAME <u>Peter Whittington</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Johnson</u>	
16. SOCIAL SECURITY NO. <u>220-12-0761</u>		17. INFORMANT'S ADDRESS <u>Alveta Whittington Marion Md.</u>	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Cancer, gastric</u> ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____ (C) _____ II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____			INTERVAL BETWEEN ONSET AND DEATH <u>2</u> <u>1</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) _____	
21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>8 P</u> M, from the causes and on the date stated above. SIGNATURE <u>C. Rawley</u> M.D. ADDRESS <u>Crisfield Md</u> DATE SIGNED _____			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>8/12/58</u>	NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	LOCATION (City, town, or county) <u>Marion Sta. Md.</u> (State) <u>Md.</u>
24. REC'D BY REGISTRAR <u>Aug 18 '58</u>	REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> ADDRESS <u>Marion Sta. Md.</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cristiell</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whites Road - Marion Station</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>McCready Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>William Edward Whittington</u>		4. DATE OF DEATH <u>Aug. 24 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1913</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea-food Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marion Station</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sherman Whittington</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>15-5-07-678</u>	
17. INFORMANT <u>Sherman Whittington - Marion Sta., Md.</u>		Address <u>Marion Station, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause. Perline for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot in right upper chest with pistol</u> 981X DUE TO <u>caused internal hemorrhage shock.</u> Conditions, if any, which gave rise to immediate cause (b) <u>caused internal hemorrhage shock.</u> DUE TO <u>caused internal hemorrhage shock.</u> Cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was on Street at 4th Main when</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>he was shot by a man</u>	
20c. TIME OF INJURY Month, Day, Year <u>5. Hour a.m. 8:24 1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>on 4th St.</u>	20f. City or town <u>Cristiell</u> (County) <u>Somerset</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Wm. H. Coulbourn</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Wm. H. Coulbourn M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Aug 28 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Marion Sta., Som Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Shad - Marion Sta., Md.</u>		ADDRESS <u>Marion Station, Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

William H. Coulbourn, M.D.
DEPUTY MEDICAL EXAMINER
MEDICAL CERTIFICATION NUMBER

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09497

Reg. Dist. No.

9503

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 21 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HENRY WILLIAMS		4. DATE OF DEATH Month Day Year AUGUST 28 1958	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/1915
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WILLIAMS		14. MOTHER'S MAIDEN NAME VIOLA KENNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-485648	
17. INFORMANT Address ADELAIDE WILLIAMS, MARION, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Condition (Embolus) 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abdominal Adhesions DUE TO (c) Various Premature myocardial		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days - 3 days 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abdominal Adhesions myocardial		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 1958 to Aug 28 1958 that I last saw the deceased alive on 8-28 1958 , and that death occurred at 3:30 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE George C. Coulbourn M.D. MARION STATION, MD.			
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D. MARION STATION, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 31-1958	
22c. NAME OF CEMETERY OR CREMATORY FAMILY CM		22d. LOCATION (City, town, or county) (State) MARION SOM. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H Ward Marion, Md.		24a. REC'D BY REGISTRAR DATE SEP 4 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

1900

APR 1 1900
NEW YORK
BROOKLYN

1. Name of deceased: John J. Smith
2. Age: 45
3. Sex: Male
4. Color: White
5. Height: 5 ft 8 in
6. Weight: 160 lbs
7. Occupation: Bookkeeper
8. Cause of death: Heart disease
9. Date of death: April 1, 1900
10. Place of death: Home
11. Signature of physician: Dr. J. H. Jones
12. Signature of registrar: John A. Smith
13. Signature of undertaker: John A. Smith
14. Signature of witness: John A. Smith
15. Signature of witness: John A. Smith